PRINTED: 12/24/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		17E242	B. WING _			12	/24/2014
	ROVIDER OR SUPPLIER	LTCU		206 GR	TADDRESS, CITY, STATE, ZIP CODE RAND AVE ARYS, KS 66536		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE.	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	8	FO	000			
F 253 SS=E	Health Resurvey. 483.15(h)(2) HOUSE MAINTENANCE SEI The facility must promaintenance service sanitary, orderly, and This REQUIREMENT by: The facility reported The sample included observation, record a facility failed to provienvironment for resident facility failed to provience facility failed to	vide housekeeping and es necessary to maintain a dicomfortable interior. T is not met as evidenced a census of 32 residents. I 12 residents. Based on review, and interview, the de a comfortable and clean dents on 1 of 2 hallways. T dated 12/22/14 at 9:00 A.M. intenance/housekeeping	F2	253			
	patched along the work bed. Throughout the environmentenance/housekacknowledged the along the work bed.						
LABORATORY	I DIRECTOR'S OR PROVIDER	/SUPPLIER REPRESENTATIVE'S SIGNATUR	RE		TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days

following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Facility ID: H075101

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	' '	DATE SURVEY COMPLETED
		17E242	B. WING			12/24/2014
	ROVIDER OR SUPPLIER	тси		STREET ADDRESS, CITY, STATE, ZIP CODE 206 GRAND AVE ST MARYS, KS 66536		
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F 253	in order to provide a spreventive maintenar implemented to prom	nce and Inspections revealed safe environment, a nce program would be ote the maintenance of ses in a state of good repair maintain a clean and	F 25	53		
F 278 SS=D	ACCURACY/COORE The assessment must resident's status. A registered nurse meach assessment wit participation of health	of the state of th	F 27	78		
	assessment is complement in a resident assessment penalty of not more than assessment.	completes a portion of the n and certify the accuracy of sessment. Medicaid, an individual who y certifies a material and esident assessment is ey penalty of not more than ssment; or an individual who y causes another individual nd false statement in a is subject to a civil money				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED		
		17E242	B. WING	 	12/24/2014		
	ROVIDER OR SUPPLIER	LTCU		STREET ADDRESS, CITY, STATE, ZIP CODE 206 GRAND AVE ST MARYS, KS 66536			
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F 278	Continued From pag material and false sta		F 27	78			
	by: The facility reported The sample included observation, record r facility failed to compresident for hospices Findings included: - The Significant Ch Data Set (MDS) date revealed the residen Mental Status (BIMS impairment), and rec The MDS lacked doc a life expectancy of I The signed telephon revealed orders for h diagnosis of Alzheim mental deterioration and memory failure), six months, provide on not resuscitate (D Observation on 12/2: resident layed in bed On 12/23/14 at 9:52 staff E stated the MD resident had less that expectancy.	e order dated 8/7/14 ospice services with a er's Disease (progressive characterized by confusion life expectancy of less than comfort measures only, and NR). 2/14 at 8:30 A.M. the					

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F 278	Continued From pag	ge 3	F 27	8		
	Planning Process re assess residents thr with the facility to pro- meet the resident's r	sident Assessment and Care vealed qualified staff would oughout the resident's stay ovide the appropriate care to needs. provide a comprehensive resident who received				
	10/8/14 for resident Interview for Mental (severe cognitive im	imum Data Set (MDS) dated #32 revealed a Brief Status (MDS) score of 5 pairment). cumentation the resident fell				
	revealed the residen nursing staff found the of her/his living room	ated 8/8/14 at 12:00 P.M. It's chair alarm sounded and the resident standing in front to chair. The resident lost staff assisted the resident to				
	sat in a recliner chai with a chair alarm in On 12/23/14 at 9:52 staff E stated the Qu	A.M. administrative nursing larterly MDS should have				
	Long Term Care Res Planning Process re assess residents thr	edure dated 11/2003 titled sident Assessment and Care vealed qualified staff would oughout the resident's stay ovide the appropriate care to				

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		17E242	B. WING			12/24/2014		
	ROVIDER OR SUPPLIER ITY HOSPITAL ONAGA	LTCU		STREET ADDRESS, CITY, STATE, ZIP CODE 206 GRAND AVE ST MARYS, KS 66536	•			
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F 278	Continued From pag		F 27	78				
F 280 SS=E	assessment for this with a history of falls 483.20(d)(3), 483.10		F 28	30				
00 L	The resident has the incompetent or other incapacitated under	e right, unless adjudged rwise found to be the laws of the State, to ng care and treatment or						
	within 7 days after the comprehensive assessinterdisciplinary team physician, a register for the resident, and disciplines as determand, to the extent prothe resident, the resident in the re	re plan must be developed the completion of the essment; prepared by an in, that includes the attending the developed nurse with responsibility other appropriate staff in mined by the resident's needs, acticable, the participation of dent's family or the resident's and periodically reviewed m of qualified persons after						
	by: The facility identified The sample size incl							

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F 280	-Findings included: - The significant char (MDS) dated 7/18/14 the resident had sever required limited to existaff members for train. The quarterly MDS diresident had severe or required total assistant transfers and locomowalk at this time. The care plan was rethe resident had a shit two staff. The care plan resident required a total transfers. Observation on 12/23 staff O and direct carresident using a total bed to wheelchair. Interview on 12/22/14 staff Q revealed the susing a total mechanic capable of walking. On 12/22/14 at 3:17 Frevealed the direct carresident using a total and no longer had the administrative nursing updating the care plans and the care plans	inge Minimum Data Set for resident #33 revealed ere cognitive impairment and tensive assistance of two insfers and locomotion. The resident did not expected the cognitive impairment and ince of two staff members for tion. The resident did not expected wiffling gait and walked with an also revealed the tal mechanical lift for expected the mechanical lift from his/her expected the resident cal lift, and he/she was not expected the mechanical lift at all times, a ability to walk. The great staff was responsible for ins. A.M. administrative nursing expected the staff was responsible for ins.	F2	280				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION	(X3)	(X3) DATE SURVEY COMPLETED	
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F 280	administrative nursin updating the care play voiced that resident a been updated since it that time. The policy and proceplan dated 9/1/14 protection and the care plan would be modified intervention. The facility failed to use impaired residents caresident's physical caresident and lower bilateral (bresident received resident receiv	ccurate for each resident. The g staff were in charge of ans as needed. He/she # 33 care plan should have he/she was not walking at edure for revising the care ovided by the facility revealed be updated with new or is. update this cognitively are plan to reflect the apability including that he/she mum Data Set (MDS) dated # 1 revealed the resident impairment and had upper ooth sides) impairment. The storative nursing and wore a d on 11/13/14 revealed the storative nursing 5 to 7 times and and elbow splint daily bedtime. lan progress notes revealed want to continue restorative using him/her to much pain.	F2		MENC 1)		
	resident sat in his/he place. On 12/22/14 at 1:39	2/14 at 11:23 A.M. the r wheelchair with no splint in P.M. the resident sat in siting with family not wearing					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		17E242	B. WING _		12/2	24/2014
	ROVIDER OR SUPPLIER	LTCU	•	STREET ADDRESS, CITY, STATE, ZIP CODE 206 GRAND AVE ST MARYS, KS 66536	•	
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F 280	staff R stated he/sh nursing and the res restorative program as it caused him/he On 12/23/14 at 9:04 revealed the reside splint due to pain, a reflect this. On 12/23/14 at 10:2 staff D revealed the at this time as reflect note it was causing Administrative nursi and expected the cawas not receiving residents decision to residents decision to residents decision to restorative program. The Significant che (MDS) dated 12/3/14 the resident had see	14 at 2:23 P.M. direct care e was in charge of restorative ident was not currently on a which included his/her splint r pain. 4 A.M. licensed nursing staff J int no longer wears the hand ind expected the care plan to 23 A.M. administrative nursing resident did not wear a splint cted in the care plan progress him/her too much pain. ing staff revised care plans are plan to reflect the resident estorative therapy or a splint. Redure for revising the care rovided by the facility revealed be updated with new or ins. update this cognitively care plan to reflect the o discontinue his/her anage Minimum Data Set 4 for resident #34 revealed vere cognitive impairment and	F 2	80		
	(MDS) dated 12/3/1 the resident had set he/she required ext members for transfer. The Activities of Da	4 for resident #34 revealed vere cognitive impairment and ensive assistance from 2 staff				

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F 280	The care plan revise resident was assisted the sit to stand lift for the care plan also id assisted by two staff mechanical lift for trace. Observation on 12/2 resident was assisted the total mechanical his/her bed. On 12/22/14 at 3:07 revealed the resident mechanical lift for al On 12/23/14 at 9:04 revealed the resident and the care plan would resident transfers. The policy and proceptant dated 9/1/14 procep	dent was transferred. In don 12/15/14 revealed the ad by two staff members with a transfers and could walk, entifies the resident was a members with the full ansfers. In an	F 28	30	
	care he/she was rec	are plan to reflect the current eiving while transferring. um Data Set (MDS) dated # 13 revealed he/she had			

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		17E242	B. WING			12/24/2014	
	ROVIDER OR SUPPLIER	тси		2	TREET ADDRESS, CITY, STATE, ZIP CODE 06 GRAND AVE IT MARYS, KS 66536		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 280	displayed continuous delirium including ina retardation. The reside more staff for bed more eating, and personal steady and was only assistance from surfatelyshe received 7 domedication (medication sychosis; any major characterized by a gratesting), 7 doses of a (medication used for abnormal emotional sexaggerated feelings and emptiness), and medication (medication staff had not secured on the mechanical lift.	ily decision making. He/she signs and symptoms of tention and psychomotor dent was dependent on 2 or obility, transfer, dressing, hygiene. He/she was not able to stabilize with staff ace-to-surface transfers. Uses of an antipsychotic on used for the treatment of mental disorder coss impairment in reality in antidepressant medication the treatment of depression; state characterized by of sadness, worthlessness 7 doses of an antianxiety on used for the treatment of notional reaction rehension, uncertainty and the 7 day look back period. Sea Assessment regarding ident was at risk for falls due al condition. Treview date of 11/6/14 awas unable to bear weight awareness. Staff used a full ers. for the 11/25/14 fall revealed one of the straps properly a which led to the fall. Staff ing proper use of the lift.	F	280			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		17E242	B. WING _			12/	24/2014
	ROVIDER OR SUPPLIER	LTCU	•	206	EET ADDRESS, CITY, STATE, ZIP CODE GRAND AVE MARYS, KS 66536	•	-
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 280	Observation on 12/22/1 the resident rested of closed. Interview on 12/22/1 staff H revealed the (ADON) and/or adm update the care plan plan to be revised afformation of the management of the care plan to be updated afformation of the management	2/14 at 9:14 A.M. revealed quietly in bed with his/her eyes 4 at 4:27 P.M. with licensed assistant director of nursing inistrative nursing staff at Staff H expected the care fiter each fall. 4 at 8:43 A.M. with direct at he/she expected the care fiter each fall to prevent that one and so staff were 4 at 9:02 A.M. with licensed ed the assistant of the ADON attor updated the care plan. Care plan to be updated after at 9:24 A.M. with lighter each ed staff failed to update this after his/her most recent fall. by the facility with a revision garding the mechanical lift of fasten the straps to the in the bottom strap to the ides. review and/or revise the care ly impaired resident after a	F2	280			
F 323	· ·		F3	323			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		17E242	B. WING			2/24/2014	
	ROVIDER OR SUPPLIER	LTCU		STREET ADDRESS, CITY, STATE, ZIP CO 206 GRAND AVE ST MARYS, KS 66536			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 323 SS=E	HAZARDS/SUPERV The facility must ensenvironment remains as is possible; and e	ISION/DEVICES	F 3.	23			
	by: The facility reported The sample included observation, record r facility failed to main at or below 120 degr	T is not met as evidenced a census of 32 residents. I 12 residents. Based on review, and interview, the tain hot water temperatures rees Fahrenheit (F) for one of site, and failed to properly dent with a Hoyer lift.					
	North hallway showe temperature of 127.4 of 124.5 F. A North h hot water temperatur shower room and ba stood open. The Bist	2/18/14 at 8:30 A.M. the er room sink had a hot water 4 F and shower temperature hallway bathroom sink had a re of 124.5 F. The door to the throom were unlocked and tro (a kitchenette located by a hot water temperature of					
	of the hot water temp acknowledged the ho would adjust the tem	A.M. seeping staff X was informed peratures and she/he of water temperatures and aperature of the hot water. of water temperatures were					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 323	staff D stated the factognitively impaired On 12/18/14 at 10:20 hallway hot water ter again and revealed the shower sink, 132 the North hallway ba Bistro sink. On 12/18/14 at 11:0 maintenance/housek adjusted the hot water. Record review on 12 Temperature Readin monthly hot water ch December 2014 was On 12/18/14 from 9:0 revealed the followin the North resident ro 124.6 degrees F, and On 12/18/14 at 4:58 water temperature in	A.M. administrative nursing ility had three independent mobile residents. O.A.M. revealed the North inperatures were temped a temperature of 126.5 F in .2 F in the shower, 125.6 in throom and 125.2 F in the A.M. seeping staff X stated she/he er and would take time to /18/14 revealed a Water g log with documentation of ecks. The month of blank. O.O. A.M. to 5:30 P.M. g hot water temperatures on oms were 127.0 degrees F,	F 323	,		
	staff A and administration plumber was notified and would come to the water lines. They als	4 at 5:13 P.M. administrative ative nursing staff D stated a of the hot water concerns ne facility to inspect the hot o stated the hot water would orth hallway shower room,				

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F 323	be provided in the So Bistro door locked. The policy and proced Monitoring of Hot Wathe maintenance depowater temperature we temperatures would be to 115 degrees F. The facility failed to matemperature weekly as	All evening showers would uth shower room and the dure dated 11/2003 titled ter Temperature revealed artment would test the hot eekly and hot water be kept between 98 degrees nonitor hot water and failed to maintain hot grees F and 115 degrees F	F	323			
	11/5/14 for resident # memory problems an cognitive skills for dai displayed continuous delirium including inar retardation. The resid more staff for bed more eating, and personal steady and was only assistance from surfa He/she received 7 do medication (medication psychosis; any major characterized by a gratesting), 7 doses of an (medication used for abnormal emotional sexaggerated feelings	ly decision making. He/she signs and symptoms of tention and psychomotor ent was dependent on 2 or bility, transfer, dressing, hygiene. He/she was not able to stabilize with staff ce-to-surface transfers. ses of an antipsychotic on used for the treatment of mental disorder coss impairment in reality in antidepressant medication the treatment of depression;					

AND DUAN OF CORRECTION IDENTIFICATION NUMBER:		l ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 323	anxiety; mental or encharacterized by applirrational fear) during. The 11/5/14 Care Ar falls revealed the rest to physical and men. The care plan with a revealed the resider and had poor safety body lift for all transf. The 8/4/14, 11/3/14, assessment revealed he/she was at risk for the nurse's note dar revealed staff was a transfer using a medicame loose and the While falling the resilift and his/her head. The fall investigation staff had not secure which led to the fall. proper use of the lift. Observation on 12/22/1 staff H revealed the fall risk due to poten reported the fall that	ion used for the treatment of motional reaction prehension, uncertainty and go the 7 day look back period. ea Assessment regarding sident was at risk for falls due tal condition. review date of 11/6/14 at was unable to bear weight awareness. Staff used a full fers. and 11/25/14 fall risk do a score of 15, indicating or falls. ted 11/25/14 at 7:45 A.M. sesisting the resident with chanical lift when a strap resident fell to the floor. dent hit his/her back on the hit the floor. In for the 11/25/14 fall revealed do one of the straps properly Staff was educated regarding	F 323	3		

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F 323	Interview on 12/23/14 nursing staff I reveale educated on the prop and was reeducated a fair. Interview on 12/23/14 administrative nursing educated upon hire relift. He/she expected when transferring res The policy provided b date of 7/30/2014 reg revealed staff were to	ides were reeducated on the or transfers. at 9:02 A.M. with licensed ad upon hire staff were er use of the lift for transfers at the facility's annual skills at 9:57 A.M. with g staff D revealed staff were egarding proper use of the staff to use proper technique idents using a lift. by the facility with a revision arding the mechanical lift of fasten the straps to the the bottom strap to the	F 3			
	cognitively impaired in technique with transfer 483.25(I) DRUG REGUNNECESSARY DRUCK Each resident's drug unnecessary drugs. Adrug when used in extended the duplicate therapy); or without adequate more indications for its use adverse consequences should be reduced or combinations of the reduced the second transfer in the	regimen must be free from An unnecessary drug is any acessive dose (including for excessive duration; or intoring; or without adequate c or in the presence of as which indicate the dose discontinued; or any	F3	29		

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		17E242	B. WING		12/24/2014	
	ROVIDER OR SUPPLIER	LTCU		STREET ADDRESS, CITY, STATE, ZIP CODE 206 GRAND AVE ST MARYS, KS 66536	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF	D BE COMPLETION	
F 329	who have not used a given these drugs ur therapy is necessary as diagnosed and do record; and residents drugs receive gradua behavioral interventions.	must ensure that residents intipsychotic drugs are not aless antipsychotic drug to treat a specific condition ocumented in the clinical so who use antipsychotic all dose reductions, and	F 32	9		
	by: The facility identified The sample included observation, record r facility failed to deve for psychotropic med #33, #34) of 5 reside medications.	T is not met as evidenced If a census of 32 residents. If 12 residents. Based on review, and interview the lop specific target behaviors lication use for 4 (#2, #13, ants reviewed for				
	10/16/14 for resident Interview for Mental indicating severe cog was totally depender mobility, transfer, dre resident received 7 in of an antipsychotic in for the treatment of p disorder characterize reality testing), 7 dos	m Data Set (MDS) dated #2 revealed a Brief Status score (BIMS) of 5, gnitive impairment. He/she nt on 2 or more staff for bed essing, and toilet use. The njections of insulin, 7 doses nedication (medication used esychosis; any major mental ed by a gross impairment in these of an antidepressant on used for the treatment of				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '			(X3) DATE SURVEY COMPLETED	
		17E242	B. WING			12/	24/2014
	ROVIDER OR SUPPLIER	тси		2	TREET ADDRESS, CITY, STATE, ZIP CODE 06 GRAND AVE ST MARYS, KS 66536	•	-
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 329	doses of a diuretic (m formation and excreti look back period. The 10/20/14 Care A psychotropic medicate resident was started a 2010 due to seeing J talking nonstop, and diagnoses of major d dementia (progressive characterized by failing Parkinson's (slowly periodicate characterized the fingers, masklike rigidity and weakness. The Care plan with a revealed staff gave monitored for side efformation of the physician's order revealed the following dates: 4/20/10 Rememedication), 6/11/10 medication). The telephone order Lexapro (antidepression discontinued. The quarterly evaluate medication use dated behaviors that warramedications included	all emotional state ggerated feelings of ess and emptiness), and 7 nedication to promote the fon of urine) during the 7 day area Assessment regarding tion use revealed the on these medications in esus in his/her window, agitation. He/she had the epression with psychosis, remental disordering memory, confusion), and rogressive neurologic and by resting tremor, rolling of faces, shuffling gait, muscle is). Tevision date of 10/27/14 nedications as ordered and fects and effectiveness. The sheet signed 12/2/14 gredications and start ron (antidepressant Seroquel XR (antipsychotic dated 9/26/14 revealed teant medication) was	F	3329			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	1, ,	(X3) DATE SURVEY COMPLETED		
		17E242	B. WING			12/24/2014	
	ROVIDER OR SUPPLIER	тси	STREET ADDRESS, CITY, STATE, ZIP CODE 206 GRAND AVE ST MARYS, KS 66536		,	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 329		ring sheets for October	F 3	29			
	showed the resident and Seroquel. The follacked specific target monitor for this reside	4, and December 2014 received Lexapro, Remeron, rm was standardized and behaviors for staff to ent. Also, this resident had since September 2014.					
		2/14 revealed the resident cliner in his/her room with					
	nursing staff H revea forms were standardi resident's receiving p Staff H reported the a the behavior monitori acknowledged the fo behaviors. He/she als difficult to determine medications since the	rms lacked specific target so acknowledged it would be effectiveness of the ere were multiple classes of					
		th no specific target I with them. Staff H reported onger receiving Lexapro.					
	nursing staff I revealed behaviors seen on the specific target behave acknowledged it wou	at 9:02 A.M. with licensed and that staff document any e forms and they lacked iors for each resident. Staff I lid be beneficial for staff to naviors to watch for to ess of medications.					
	acknowledged the be	at 9:24 A.M. with g staff E revealed he/she chavior monitoring forms behaviors for the resident					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		17E242	B. WING		12/24/2014	
	ROVIDER OR SUPPLIER	ALTCU	200	REET ADDRESS, CITY, STATE, ZIP CODE 6 GRAND AVE - MARYS, KS 66536	,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION	
F 329	Interview on 12/23/ administrative nursi would expect the be be individualized fo acknowledged this Lexapro. The policy provided date of 11/2003 reg revealed the nurse developing the beh- identify specific disp assessed and indiv them in the spaces The facility failed to behavior monitoring cognitively impaired psychotropic medic The annual Minim 11/5/14 for resident memory problems a cognitive skills for d displayed continuou delirium including ir retardation. The res more staff for bed in eating, and persona doses of an antipsy	nt no longer received Lexapro. 14 at 9:57 A.M. with Ing staff D revealed he/she ehavior monitoring sheets to r each resident and he/she resident no longer received I by the facility with an effective larding behavior monitoring was responsible for avior monitoring sheet and blayed (target) behaviors to be idual interventions by writing provided. Individualize and update the g sheet for this severely d resident receiving	F 329			
	mental disorder cha impairment in reality antidepressant med the treatment of del state characterized	aracterized by a gross y testing), 7 doses of an dication (medication used for pression; abnormal emotional by exaggerated feelings of ness and emptiness), and 7				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		17E242	B. WING	· · · · · · · · · · · · · · · · · · ·		12/24/2014
	ROVIDER OR SUPPLIER	LTCU		STREET ADDRESS, CITY, STATE, ZIP CODE 206 GRAND AVE ST MARYS, KS 66536		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 329	used for the treatme emotional reaction of apprehension, unce during the 7 day loo. The 11/6/14 Care Ar psychotropic medication had anxiety (mental characterized by appirrational fear), and I (sensing things while real, but the mind or The care plan with a revealed the resider cried out. The physician's order revealed the following dates: 5/3/11 Trazac medication), 11/13/1 medication). The quarterly evaluated medication use dates.	ety medication (medication nt of anxiety; mental or haracterized by rtainty and irrational fear) k back period. ea Assessment for ation use revealed he/she due to yelling out at night, or emotional reaction prehension, uncertainty and had a history of hallucinations awake that appear to be leated). It reviewed date of 11/6/14 at was resistive to cares and ler sheet signed 12/2/14 and medications and start done (antidepressant 3 Ativan cream (antianxiety 3 Seroquel (antipsychotic	F 32	, , , , , , , , , , , , , , , , , , ,		
	2014, November 20 showed the resident Trazadone, and Ativ standardized and lar for staff to monitor for	oring sheets for October 14, and December 2014 received Seroquel, an cream. The form was cked specific target behaviors				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		17E242	B. WING		12/24/2014	
	ROVIDER OR SUPPLIER ITY HOSPITAL ONAGA	LTCU	20	REET ADDRESS, CITY, STATE, ZIP CODE 6 GRAND AVE T MARYS, KS 66536	,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 329	Interview on 12/22/ nursing staff H reversident's receiving Staff H reported the the behavior monitor acknowledged the fibehaviors. He/she adifficult to determine medications since to medications listed with behaviors associated this resident freque. Interview on 12/23/ care staff S revealed yelled out. Interview on 12/23/ nursing staff I reveated behaviors seen on specific target behaviors acknowledged it work the staff of the seen	quietly in bed with his/her eyes 14 @ 4:27 P.M. with licensed aled the behavior monitoring dized and put into place for all psychotropic medications. admitting nurse developed oring forms. Staff H forms lacked specific target also acknowledged it would be a effectiveness of the here were multiple classes of with no specific target add with them. Staff H reported	F 329			
	administrative nursi	14 at 9:57 A.M. with ng staff D revealed he/she ehavior monitoring sheets to				

AND DLAN OF CORRECTION IDENTIFICATION NUMBER		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		17E242	B. WING			12/	24/2014
	ROVIDER OR SUPPLIER	тси		2	TREET ADDRESS, CITY, STATE, ZIP CODE 06 GRAND AVE ST MARYS, KS 66536	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 329	date of 11/2003 regarevealed the nurse we developing the behavidentify specific displassessed and individing them in the spaces p. The facility failed to immonitoring sheet for impaired resident recomedications. The Physician's Or 12/2/14 for resident #depression (abnormational characterized by exasadness, worthlessned dementia (progressive characterized by failing anxiety (mental or encharacterized by apprirrational fear) and agonitive impairment antidepressants, and The Communication (CAA) dated 12/8/14 very anxious and crieresident had spent tirunit and his/her behaviore.	each resident. by the facility with an effective rding behavior monitoring as responsible for vior monitoring sheet and ayed (target) behaviors to be ual interventions by writing rovided. Individualize the behavior this severely cognitively seiving psychotropic der Sheet (POS) signed on a safe and emptiness of all emotional state ggerated feelings of the ess and emptiness), we mental disorder and memory, and confusion), notional reaction rehension, uncertainty and	F	329			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 1	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		17E242	B. WING		12/24/2014	
	ROVIDER OR SUPPLIER	A LTCU		STREET ADDRESS, CITY, STATE, ZIP CODE 206 GRAND AVE ST MARYS, KS 66536	1.2.2.1.2011	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION	
F 329	resident had cognital anxiety. Review of the POS the resident received Seroquel (an antips milligrams (mg) by ordered on 11/26/1 this medication Diazepam (an antist three times daily for 11/26/14 Depakote (an antist mood stabilization) for mood stabilization) for mood stabilizer Trazadone (an antiperoperoperoperoperoperoperoperoperopero	ated on 12/15/14 revealed the rive loss, yelled out and had signed on 12/2/14 revealed ed the following medications: sychotic medication)12.5 mouth (PO) five times daily 4 and lacked a diagnosis for anxiety medication) 2 mg PO ranxiety/agitation ordered on eizure medication used for 125 mg PO four times daily ordered on 11/26/14 depressant medication) 50 mg sion ordered on 8/14/14 ate (an antidepressant g PO daily for obsessions 4. cations were ordered as hich the resident received	F 329			
	Trazadone, Clonaz was standardized a behaviors for staff t	epam, and Seroquel. The form and lacked specific target to monitor for this resident.				

	DF DEFICIENCIES CORRECTION			' '	(X3) DATE SURVEY COMPLETED		
		17E242	B. WING _			12	/24/2014
	ROVIDER OR SUPPLIER	A LTCU		206 G	ET ADDRESS, CITY, STATE, ZIP CODE RAND AVE ARYS, KS 66536		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 329	Trazadone, Clonaz was standardized a behaviors for staff. Review of the Deca sheets revealed the Trazadone, Fluvox was standardized a behaviors for staff. The resident also repeakote, Zyprexa behavior monitorin. Observation on 12 resident was yelling into room and held calmed him/her do. Interview on 12/22 nursing staff H reveforms were standaresident's receiving Staff H reported the behaviors. He/she difficult to determine medications since medications listed behaviors associated the behavior associated behaviors associated beindividualized for the standard resident's receiving staff H reported the behaviors associated behaviors associated behaviors associated behaviors associated behaviors associated beindividualized for the standard resident standard resident standard resident standard resident standard resident standard resident resident standard resident r	resident received Lexapro, repam, and Seroquel. The form and lacked specific target to monitor for this resident. The form and lacked specific target to monitor for this resident. The form and Seroquel. The form and lacked specific target to monitor for this resident. The form and lacked specific target to monitor for this resident. The form and lacked specific target to monitor for this resident. The form lacked specific target to monitor for this resident. The form lacked specific target the form and lacked specific target the form lack specific targeted also acknowledged it would be the effectiveness of the there were multiple classes of with no specific target the dwith them. The form lack specific target the dwith them.	F	329			

12/24/2014
ZIP CODE
OF CORRECTION (X5) ACTION SHOULD BE COMPLETION TO THE APPROPRIATE JENCY) (X5) COMPLETION DATE
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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		17E242	B. WING		12/24/2014
	ROVIDER OR SUPPLIER	LTCU	2	STREET ADDRESS, CITY, STATE, ZIP CODE 206 GRAND AVE ST MARYS, KS 66536	, .2.2.1.20.1.
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 329	milligrams (mg) by nordered on 6/25/14 Seroquel (an antipsy daily for acute psych Seroquel 100 mg PC psychosis ordered on Restoril (a hypnotic needed (PRN) for in Ativan (an antianxiet every two hours PRI order date. Review of the Octob behavior monitoring resident had orders and Restoril The for lacked specific targe monitor for this resident rested quiet Interview on 12/22/1 nursing staff H reveat forms were standard resident's receiving Staff H reported the the behavior monitor acknowledged the fobehaviors. He/she a difficult to determine medications since the medications listed w behaviors associated.	essant medication) 20 nouth (PO) for depression (chotic medication) 50 mg PO noisis ordered on 6/25/14 (2) at bedtime (HS) for acute (n 6/25/14 (medication) 15 mg PO as (somnia ordered on 8/27/14 (by medication) 0.5 mg PO (noisis ordered on 8/27/14 (medication) 15 mg PO as (somnia ordered on 8/27/14 (somedication) 0.5 mg PO (noisis ordered on 8/25/14 (somedication) 0.5 mg PO (noisis ordered on 8/25/14 (somedication) 0.5 mg PO (noisis ordered on 6/25/14 (somedication) 0.5 mg PO (noisis ordered on 8/25/14 (somedication) 0.5 mg PO (noisis ordered on 8/25/14 (somedication) 0.5 mg PO (noisis ordered on 6/25/14 (somedication) 0.5 mg PO (noisis ordered on 8/27/14 (somedication) 0.5 mg PO (no	F 329		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E242	B. WING			12/:	24/2014
	ROVIDER OR SUPPLIER	лси	•	20	TREET ADDRESS, CITY, STATE, ZIP CODE D6 GRAND AVE T MARYS, KS 66536		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 354 SS=D	be individualized for each of the policy provided by date of 11/2003 regar revealed the nurse was developing the behavior dentify specific displays assessed and individual them in the spaces provided the spaces provided them in the spaces provided the spaces provided them in the sp	avior monitoring sheets to each resident. by the facility with an effective ding behavior monitoring as responsible for ior monitoring sheet and ayed (target) behaviors to be ual interventions by writing rovided. addividualize and update the sheets for this severely esident receiving ions. by 8 HRS 7 DAYS/WK, under paragraph (c) or (d) of ty must use the services of a t least 8 consecutive hours under paragraph (c) or (d) of ty must designate a erve as the director of basis. g may serve as a charge facility has an average daily		3329			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		17E242	B. WING			12/	24/2014
	ROVIDER OR SUPPLIER TY HOSPITAL ONAGA L	тси		2	STREET ADDRESS, CITY, STATE, ZIP CODE 106 GRAND AVE ST MARYS, KS 66536		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOUL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE		
	2014. Findings included: Review of the facilit 2014 revealed no RN for December 6th, 7th 27th and 28th. Interview on 12/22/14 staff A revealed he/sh coverage on the acute under the same licens. The policy and proced Nurse staffing provide Community Hospital a Long Term care Unit (RN's were immediate to meet the requireme 7 days a week of RN The facility failed to proced to the facility failed to proced to proced to proced to proced to procedutive hours, 7 483.35(i) FOOD PROSTORE/PREPARE/SI The facility must - (1) Procure food from considered satisfactor authorities; and	eekends during December by schedule for December coverage was scheduled a, 13th, 14th, 20th, 21st, at 3:42 P.M. administrative at was able to count RN at care side since it was sure. dure dated 12/21/14 for ad by the facility revealed and Community Hospital (LTCU) share RN's and ly available for LTCU help, ants of 8 consecutive hours, coverage. rovide RN coverage for 8 days a week. accurate coverage for 8 days a week.		354			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION G		DATE SURVEY COMPLETED
		17E242	B. WING			12/24/2014
	ROVIDER OR SUPPLIER	LTCU		STREET ADDRESS, CITY, STATE, ZIP CODE 206 GRAND AVE ST MARYS, KS 66536	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 371	Continued From pag	e 29	F 3	71		
	by: The facility had 1 kit interview, and record distribute and serve conditions on 1 of 3 of Findings included: - Observation on 12/staff DD had gloved utensils, dietary card packaging and then directly touched the continued to make the Con	-				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION		E SURVEY PLETED
		17E242	B. WING		12	/24/2014
	ROVIDER OR SUPPLIER	тси		STREET ADDRESS, CITY, STATE, ZIP CODE 206 GRAND AVE ST MARYS, KS 66536		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED (ENCY)	ULD BE	(X5) COMPLETION DATE
F 371 F 428 SS=E	staff EE revealed he/food with unclean glo technique. Interview on 12/22/14 staff DD revealed he/hamburger bun packa surface and should not the policy provided be date of 5/3/12 regard food preparation revewere prepared and semanner to maintain quutritive value. Foods prepared and served forks, spoons, spatula implement so as to apprepared foods. Staff cups, glasses, dishest touching surfaces with contact with. The facility failed to hamiltany conditions. 483.60(c) DRUG REGIEREGULAR, ACT ORTHEREGULAR, ACT ORTHEREGULAR	at 12:09 P.M. with dietary she acknowledged touching wes was not proper If at 12:29 P.M. with dietary she was aware the aging was not a clean of rest serving utensils on it. By the facility with a revision ing infection control during saled staff ensured all foods erved in the most sanitary uality, appearance and a products should be with clean tongs, scoops, as, or other suitable woid manual contact of was to handle utensils, as in such a way as to avoid the food or drink will come in andle and serve food under GIMEN REVIEW, REPORT	F 37			
	reviewed at least one pharmacist. The pharmacist must the attending physicia	report any irregularities to an, and the director of ports must be acted upon.				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		17E242	B. WING		12/24/2014
	ROVIDER OR SUPPLIER	LTCU	:	STREET ADDRESS, CITY, STATE, ZIP CODE 206 GRAND AVE ST MARYS, KS 66536	, , , , , , , , , , , , , , , , , , , ,
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLETION
F 428	Continued From pag	ge 31	F 428		
	by: The facility identifie The sample included observation, record consultant pharmace notify the facility of the target behaviors for for 4 (#2, #13, #33, for medications. The pharmacy recomme regarding the need to psychotropic medications.	_			
	10/16/14 for resident Interview for Mental indicating severe cowas totally depende mobility, transfer, dresident received 7 of an antipsychotic refor the treatment of disorder characteriz reality testing), 7 downedication (medicate depression; abnorm characterized by exadness, worthless doses of a diuretic (medicate).	um Data Set (MDS) dated t #2 revealed a Brief Status score (BIMS) of 5, gnitive impairment. He/she nt on 2 or more staff for bed essing, and toilet use. The injections of insulin, 7 doses medication (medication used psychosis; any major mental ed by a gross impairment in ses of an antidepressant cion used for the treatment of al emotional state aggerated feelings of ness and emptiness), and 7 medication to promote the tion of urine) during the 7 day			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION 3		ATE SURVEY OMPLETED
		17E242	B. WING	 		12/24/2014
	ROVIDER OR SUPPLIER	LTCU		STREET ADDRESS, CITY, STATE, ZIP CODE 206 GRAND AVE ST MARYS, KS 66536	·	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 428	Continued From pag	ge 32	F 42	28		
	psychotropic medical resident was started 2010 due to seeing a talking nonstop, and diagnoses of major of dementia (progressis characterized by fail Parkinson's (slowly progressis characterized by fail Parkinson's (slowly progressis) disorder characterized by fail Parkinson's masklike rigidity and weakness. The Care plan with a revealed staff gave monitored for side entry and the physician's order revealed the following dates: 4/20/10 Remember 11/10 medication).	ing memory, confusion), and progressive neurologic ed by resting tremor, rolling of a faces, shuffling gait, muscle es). The revision date of 10/27/14 medications as ordered and effects and effectiveness. The sheet signed 12/2/14 medications and start eron (antidepressant a Seroquel XR (antipsychotic				
	Lexapro (antidepres discontinued. The quarterly evalua medication use date behaviors that warra medications included	d 10/14/14 revealed the inted the use of these d seeing people, kids, and				
	The behavior monito 2014, November 20 showed the resident and Seroquel. The fo	oring sheets for October 14, and December 2014 received Lexapro, Remeron, form was standardized and to behaviors for staff to				

STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION		` IDENTIFICATION NUMBER:		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		17E242	B. WING			2/24/2014	
	ROVIDER OR SUPPLIER ITY HOSPITAL ONAGA	LTCU		STREET ADDRESS, CITY, STATE, ZIP CO 206 GRAND AVE ST MARYS, KS 66536	·		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 428	The Monthly Regime consultant pharmaci medications and rec 12/30/13, 1/0/14, 2/15/23/14, 6/13/14, 7/110/14/14, 11/21/14, pharmacists notes for recognized and notif specific target behave Lexapro on the behavior on the behavior on the behavior were standard resident's receiving Staff H reveation on 12/22/11 nursing staff H reveation were standard resident's receiving Staff H reported the the behavior monitor acknowledged the for behaviors. He/she a difficult to determine medications listed where the resident was not the resident was not the resident was not the specific target behaviors seen on the specific target behaviors acknowledged it would be the second to the specific target behaviors acknowledged it would be the second to the specific target behaviors acknowledged it would be the second to the se	lent. Also, this resident had be since September 2014. In Review revealed the st reviewed the resident's ord on the following dates: 14/14, 3/14/14, 4/11/14, 11/14, 8/15/14, 9/12/14, and 12/8/14. Review of the ailed to show he/she fied the facility of the lack of viors and continued listing of avior monitoring sheets. 2/14 revealed the resident cliner in his/her room with 4 @ 4:27 P.M. with licensed aled the behavior monitoring lized and put into place for all psychotropic medications. admitting nurse developed ring forms. Staff H orms lacked specific target lso acknowledged it would be	F 42	28			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION B	(X3) DATE COMP	SURVEY
		17E242	B. WING		12/	24/2014
	ROVIDER OR SUPPLIER	LTCU		STREET ADDRESS, CITY, STATE, ZIP CODE 206 GRAND AVE ST MARYS, KS 66536	, . <u></u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 428	Continued From pag	e 34	F 42	28		
	acknowledged the belacked specific targe and that this resident Interview on 12/23/1 administrative nursin would expect the belacknowledged this relevance. Interview on 12/23/1 consultant pharmacis review the behavior feel target behaviors the effectiveness of particular pharmacis always ensure the material behavior monitoring. The policy provided date of 11/2003 regar revealed the nurse was developing the behavior in the spaces parents of particular pharmacis reviews on each resident and that the policy provided in the spaces parents of parents of parents of the policy provided in the policy provided in the spaces parents of parents of the policy provided in the policy provided in the policy provided in the policy provided in the spaces parents of the policy provided in the policy provided	g staff E revealed he/she ehavior monitoring forms to behaviors for the resident to no longer received Lexapro. 4 at 9:57 A.M. with g staff D revealed he/she havior monitoring sheets to each resident and he/she esident no longer received. 4 at 10:52 A.M. with st JJ revealed he/she did monitoring sheets but did not were beneficial to evaluating esychotropic medications. Exported he/she did not ledications listed on the sheets were accurate. by the facility with an effective ording behavior monitoring was responsible for vior monitoring sheet and layed (target) behaviors to be dual interventions by writing provided. by the facility dated 12/23/14 hen review revealed the st performed drug regimen dent at least monthly.				
	notify the facility of the	macist failed to recognize and neir failure to individualize vior monitoring sheet for this				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		17E242	B. WING			12/:	24/2014	
	ROVIDER OR SUPPLIER	тси		20	TREET ADDRESS, CITY, STATE, ZIP CODE 06 GRAND AVE IT MARYS, KS 66536			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 428	- The annual Minimu 11/5/14 for resident # memory problems an cognitive skills for daidisplayed continuous delirium including ina retardation. The residence staff for bed more staff for bed more staff for bed more ating, and personal doses of an antipsychused for the treatment mental disorder charal impairment in reality antidepressant medic the treatment of depressant medic the treatment of depressant medicate characterized by sadness, worthlessned doses of an antianxieused for the treatment emotional reaction chapprehension, uncert during the 7 day look The 11/6/14 Care Are psychotropic medicate received medication chad anxiety (mental control of the characterized by appirrational fear), and he (sensing things while real, but the mind creen.	mpaired resident receiving ions. m Data Set (MDS) dated 13 revealed he/she had d severely impaired ly decision making. He/she signs and symptoms of ttention and psychomotor lent was dependent on 2 or ability, transfer, dressing, hygiene. He/she received 7 notic medication (medication at of psychosis; any major acterized by a gross testing), 7 doses of an action (medication used for ession; abnormal emotional y exaggerated feelings of ess and emptiness), and 7 thy medication (medication at of anxiety; mental or haracterized by ainty and irrational fear) back period. The Assessment for ion use revealed he/she due to yelling out at night, or emotional reaction rehension, uncertainty and and a history of hallucinations awake that appear to be	F	428				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		17E242	B. WING		12/2	4/2014
NAME OF PROVIDER OR SUPPLIER COMMUNITY HOSPITAL ONAGA LTCU			STREET ADDRESS, CITY, STATE, ZIP CODE 206 GRAND AVE ST MARYS, KS 66536	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 428	Continued From pag	e 36	F 42	28		
	revealed the followin dates: 5/3/11 Trazad medication), 11/13/1 medication), 11/25/1 medication). The quarterly evalua medication use date	3 Ativan cream (antianxiety 3 Seroquel (antipsychotic				
	medications included					
	2014, November 20 ^o showed the resident Trazadone, and Ativa	an cream. The form was ked specific target behaviors				
	consultant pharmacimedications and reconsultant, 1/30/14, 2/15/23/14, 6/13/14, 7/110/14/14, 11/21/14, apharmacists notes fa	ied the facility of the lack of				
		2/14 at 2:10 P.M. revealed uietly in bed with his/her eyes				
	nursing staff H reveat forms were standard resident's receiving p	4 @ 4:27 P.M. with licensed alled the behavior monitoring ized and put into place for all psychotropic medications. admitting nurse developed ing forms. Staff H				

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE COMP	SURVEY PLETED
		17E242	B. WING _			12/	24/2014
NAME OF PROVIDER OR SUPPLIER COMMUNITY HOSPITAL ONAGA LTCU		STREET ADDRESS, CITY, STATE, ZIP CODE 206 GRAND AVE ST MARYS, KS 66536		,	1 122-12017		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CO	IDER'S PLAN OF CORRECTION ORRECTIVE ACTION SHOULD E FERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 428	acknowledged the for behaviors. He/she als difficult to determine of medications since the medications listed with behaviors associated this resident frequent. Interview on 12/23/14 care staff S revealed yelled out. Interview on 12/23/14 nursing staff I revealed behaviors seen on the specific target behaviors seen on the specific target behaviors what target behaviors what target behaviors determine effectivener reported this resident daily. Interview on 12/23/14 administrative nursing acknowledged the behavior acknowledged the behavior in the individualized for experience of periods and the periods and the periods are the periods are the periods and the periods are the periods are the periods and the periods are the period and the periods are the period and the periods are the periods	rms lacked specific target so acknowledged it would be effectiveness of the ere were multiple classes of the no specific target with them. Staff H reported by yelled out. If at 8:43 A.M. with direct the resident frequently If at 9:02 A.M. with licensed ed that staff document any eforms and they lacked ors for each resident. Staff I led be beneficial for staff to haviors to watch for to ess of medications. Staff I requently yelled out, almost at 9:24 A.M. with g staff E revealed he/she shavior monitoring forms behaviors for the resident. If at 9:57 A.M. with g staff D revealed he/she havior monitoring sheets to each resident.	F	28			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION		OATE SURVEY OMPLETED	
		17E242	B. WING	 		12/24/2014
NAME OF PROVIDER OR SUPPLIER COMMUNITY HOSPITAL ONAGA LTCU			STREET ADDRESS, CITY, STATE, ZIP CODE 206 GRAND AVE ST MARYS, KS 66536	•		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 428	Continued From pag	ge 38 arding behavior monitoring	F 42	28		
	revealed the nurse v developing the beha identify specific disp	vas responsible for vior monitoring sheet and layed (target) behaviors to be dual interventions by writing				
	regarding drug regin consultant pharmaci	by the facility dated 12/23/14 nen review revealed the st performed drug regimen ident at least monthly.				
	notify the facility of the					
	12/2/14 for resident depression (abnorm characterized by exasadness, worthless dementia (progressicharacterized by fail anxiety (mental or eigenscharacterized)	aggerated feelings of less and emptiness), ve mental disorder ing memory, and confusion), motional reaction orehension, uncertainty and				
	dated 12/3/14 revea	nge Minimum Data Set (MDS) led the resident had severe t and received antipsychotics, d antianxiety medication.				
	(CAA) dated 12/8/14 very anxious and cri	Care Area Assessment I revealed the resident was es out frequently. The ime in a geriatric psychotic				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		OATE SURVEY OMPLETED
		17E242	B. WING _			12/24/2014
	ROVIDER OR SUPPLIER	LTCU	,	STREET ADDRESS, CITY, STATE, ZIP COL 206 GRAND AVE ST MARYS, KS 66536	DE .	-
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 428	Continued From pag	e 39 viors were not improved.	F 4	128		
	The Psychotropic CA followed by a psychia regimen. The care plan update	A revealed he/she was atrist for his/her medication ed on 12/15/14 revealed the loss, yelled out and had				
	the resident received Seroquel (an antipsy milligrams (mg) by nordered on 11/26/14 this medication Diazepam (an antian three times daily for a 11/26/14 Depakote (an antisei mood stabilization) 1 for mood stabilization) 1 for mood stabilizer of Trazadone (an antide PO daily for depressi Fluvoxamine Maleate medication) 125 mg ordered on 11/26/14. The following medication heeded (PRN) in whi during the month of I Zyprexa (an antipsycevery 4 hours prn for Lorazepam (an antias	epressant medication) 50 mg ion ordered on 8/14/14 e (an antidepressant PO daily for obsessions ations were ordered as ch the resident received				
	sheets revealed the	er behavior monitoring flow resident received Lexapro, pam, and Seroquel. The form				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E242	B. WING		12/24/2014
	ROVIDER OR SUPPLIER	LTCU		STREET ADDRESS, CITY, STATE, ZIP CODE 206 GRAND AVE ST MARYS, KS 66536	·
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION
F 428	behaviors for staff to Review of the Noven sheets revealed the in Trazadone, Clonazel was standardized and behaviors for staff to Review of the Decensheets revealed the in Trazadone, Fluvoxor was standardized and behaviors for staff to The resident also recomplete to the interest of the period of the interest of the	d lacked specific target monitor for this resident. The behavior monitoring flow resident received Lexapro, cam, and Seroquel. The form d lacked specific target monitor for this resident. The behavior monitoring flow resident received Diazepam, nine, and Seroquel. The form d lacked specific target monitor for this resident. The form d lacked specific target monitor for this resident. The form d lacked specific target monitor for this resident. The form d lacked specific target monitor for this resident. The form d lacked specific target monitor for this resident. The form d lacked specific target monitor for this resident the reviewed the resident's cord on the following dates: The form d lack of specific target of the pharmacist of the pharmacist of the pharmacist of the facility to add a conference of	F 428	3	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED		
		17E242	B. WING _			12/24/2014	
	ROVIDER OR SUPPLIER	LTCU		STREET ADDRESS, CITY, STATE, ZIP CODE 206 GRAND AVE ST MARYS, KS 66536		,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 428	nursing staff H reveal forms were standard resident's receiving postaff H reported the staff	4 at 4:27 P.M. with licensed aled behavior monitoring ized and put into place for all psychotropic medications. admitting nurse developed ing forms. Staff H arm lack specific targeted so acknowledged it would be the effectiveness of the ere were multiple classes of the no specific target d with them. 4 at 10:23 A.M. g staff D revealed he/she havior monitoring sheets to each resident and to be sychotropic medications the st performed drug regimen dent at least monthly. follow pharmacy for adding a diagnosis for armacist failed to identify that individualize and update the sheets for this severely resident receiving tions. der Sheet (POS) signed on #33 revealed the diagnoses mal emotional state ggerated feelings of ess and emptiness) and	F4	28			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E242	B. WING		12/24/2014
NAME OF PROVIDER OR SUPPLIER COMMUNITY HOSPITAL ONAGA LTCU			STREET ADDRESS, CITY, STATE, ZIP CODE 206 GRAND AVE ST MARYS, KS 66536		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
F 428	Continued From page	e 42	F 428	8	
	dated 7/18/14 revealed cognitive impairment antidepressants, antimedication. The Mood Care Area 7/18/14 revealed the would pace into other would pace into other the Psychotropic CA Celexa, Restoril, Ativ. The care plan update resident displayed resuch as striking out he Review of the Decem revealed the resident medications: Celexa (an antidepremilligrams (mg) by mordered on 6/25/14 Seroquel (an antipsychaily for acute psychosis ordered on Restoril (a hypnotic meded (PRN) for ins Ativan (an antianxiety every two hours PRN order date. Review of the Octobe behavior monitoring for the control of the Cotobe behavior monitoring for the control of the Cotobe behavior monitoring for the Cotobe behavior monitori	Assessment (CAA) dated resident was restless and resident rooms. A revealed he/she received an, Seroquel and Trazadone and on 12/22/14 revealed the stlessness, and behaviors ad decreased. The POS signed 12/4/14 received the following assant medication) 20 outh (PO) for depression chotic medication) 50 mg PO osis ordered on 6/25/14 at bedtime (HS) for acute			
		was standardized and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION	` ′	ATE SURVEY DMPLETED	
		17E242	B. WING	 		12/24/2014
	ROVIDER OR SUPPLIER	LTCU		STREET ADDRESS, CITY, STATE, ZIP CODE 206 GRAND AVE ST MARYS, KS 66536	·	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 428	consultant pharmaci medications and rec 5/23/14, 6/13/14, 7/1 10/14/14, 11/21/14, 19 pharmacist 's notes recognized and notif specific target behave. Observation on 12/2 resident rested quiet Interview on 12/22/1 nursing staff H reveatorms were standard resident's receiving Staff H reported the the behavior monitor acknowledged the fobehaviors. He/she a difficult to determine medications since the medications listed where the behaviors associated interview on 12/23/1 administrative nursing would expect the behavior provided regarding drug reging consultant pharmaci	en Review revealed the st reviewed the resident's ord on the following dates: 11/14, 8/15/14, 9/12/14, and 12/8/14. Review of the failed to show he/she by the facility the lack of viors. 2/14 at 9:43 A.M. the stly in bed. 4 at 4:27 P.M. with licensed alled behavior monitoring lized and put into place for all psychotropic medications, admitting nurse developed ring forms. Staff Horm lack specific targeted also acknowledged it would be the effectiveness of the lere were multiple classes of ith no specific target d with them. 4 at 10:23 A.M. ag staff D revealed he/she havior monitoring sheets to	F 42	28		
		d to identify that the facility ze and update the behavior				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		TION I DENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION UILDING		(X3) DATE SURVEY COMPLETED	
		17E242	B. WING _		1	2/24/2014	
	ROVIDER OR SUPPLIER	тси		STREET ADDRESS, CITY, STATE, ZIP C 206 GRAND AVE ST MARYS, KS 66536	<u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 428	Continued From page	e 44	F 4	28			
	monitoring sheets for impaired resident rec medications.	this severely cognitively eiving psychotropic					
F 441 SS=E		CONTROL, PREVENT	F4	41			
	Infection Control Prog safe, sanitary and co	blish and maintain an gram designed to provide a mfortable environment and evelopment and transmission on.					
	Program under which (1) Investigates, cont in the facility; (2) Decides what pro should be applied to	blish an Infection Control it - rols, and prevents infections cedures, such as isolation, an individual resident; and d of incidents and corrective					
	prevent the spread of isolate the resident. (2) The facility must promunicable disease from direct contact will train (3) The facility must resident in the resident of the re	n Control Program ident needs isolation to infection, the facility must prohibit employees with a se or infected skin lesions ith residents or their food, if insmit the disease. equire staff to wash their ct resident contact for which eated by accepted					
	(c) Linens Personnel must hand	le, store, process and					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		17E242	B. WING		12/24/2014
	ROVIDER OR SUPPLIER	тси		STREET ADDRESS, CITY, STATE, ZIP CODE 206 GRAND AVE ST MARYS, KS 66536	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 441	Continued From page transport linens so as infection.	e 45 s to prevent the spread of	F 44	! 1	
	by: The facility identified Based on observation facility failed to utilize	r is not met as evidenced a census of 32 residents. an and staff interview the precautions to minimize the tion during one of one room			
	Findings included:				
		22/14 between 8:29 A.M. keeping staff Z wore the out room clean.			
		cleaned the toilet riser with er was wiped with damp cloth			
	Observation on 12/22 housekeeping staff Y cleaner #2.	2/14 at 9:10 A.M. mopped the floor with floor			
	were Suprox 33 (not cleaner 2 (not disinfe disinfectant) bleach (staff X reported a dry	for cleaning of the room disinfectant), Window ctant), floor cleaner #2 (not a disinfectant- housekeeping time of 10 minutes), ant with a dry time of 10			
	housekeeping staff Y	4 at approximately 8:55 A.M. revealed housekeeping ct or sanitize resident rooms			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		TON IDENTIFICATION NUMBER:) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		17E242	B. WING _			2/24/2014	
NAME OF PROVIDER OR SUPPLIER COMMUNITY HOSPITAL ONAGA LTCU			STREET ADDRESS, CITY, STATE, ZIP CODE 206 GRAND AVE ST MARYS, KS 66536		12/24/2014		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 441	if someone was sick rooms within the faci housekeeping staff vonce a week. House floor cleaner #10 is rand does not have a the facility used that wipes, bleach and R 10 minute dry time a saturate the room in minutes. Interview on 12/22/1 housekeeping staff x revealed the facility j different brand of che #16 should be used which should be don chemical must stay were expected to sat stays wet for 10 minutes gloves after cleaning Housekeeping staff x dry time of 10 minutes. The policy and procedated 2/1/2000 provinousekeeping in the	the only time that happens is leaves the facility or moves lity. He/she stated vipe the door knobs down keeping staff Y revealed the lot a disinfectant or sanitizer dry time, the only chemical disinfects was the caving e-Juv-Nal #16, which have a lot a staff must completely order for it to stay wet for 10. 4 at 11:06 A.M. with and housekeeping staff AA lost switched over to a lemicals and the Re-Juv-Nal long the toilet, and door knobs lew the every room clean. The lot the toilet, and staff the lot. Staff is to change the toilet. A revealed the bleach has a less, if staff were using it. Indicated the staff were using it.	F 4	41			